General Assembly

Committee Bill No. 6152

January Session, 2009

LCO No. **4685**

04685HB06152INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING A CATASTROPHIC MEDICAL EXPENSES POOL.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2009*) As used in sections 1 to 8, inclusive, of this act:

(1) "Commission" means the Catastrophic Medical Expenses Commission established pursuant to section 3 of this act.

(2) "Family income" means all net income from all sources received by a family in a calendar year, excluding payments or reimbursements received from the pool.

(3) "Pool" means the catastrophic medical expenses pool established pursuant to section 2 of this act.

Sec. 2. (NEW) (*Effective July 1, 2009*) (a) There is established a catastrophic medical expenses pool to provide payment or reimbursement for medical and related expenses beginning January 1, 2010, that exceed the family income levels set forth in section 6 of this act. The Office of the Healthcare Advocate shall administer the pool in

accordance with the provisions of sections 1 to 8, inclusive, of this act and with the advice of the Catastrophic Medical Expenses Commission.

(b) Services, equipment and other expenses eligible to be considered for payment or reimbursement from the pool, subject to the limitations and exclusions set forth in sections 5 and 6 of this act, include, but are not limited to: (1) Durable medical equipment, hearing aids, medical or surgical supplies, therapy services and prostheses or orthotics that are covered benefits but which were denied in whole or in part because policy or plan limitations have been reached; (2) health insurance (A) premiums, (B) copayments, (C) deductibles, (D) coinsurance, and (E) other out-of-pocket expenses paid by an applicant for a covered benefit; and (3) other items determined by the commission or persons designated by the commission pursuant to section 4 of this act to be directly related to the medical condition of the applicant and necessary to maintain the health and independence of the applicant or permit such applicant to continue to remain at home.

(c) The commission shall make publicly available a list of medical and related expenses that are eligible to be considered for payment or reimbursement from the pool. The commission shall update such list at least annually.

(d) Nothing in sections 1 to 8, inclusive, of this act shall be construed to require the Office of the Healthcare Advocate or the commission to make any payment or reimbursement of medical or related expenses to an applicant.

Sec. 3. (NEW) (*Effective July 1, 2009*) (a) There is established a Catastrophic Medical Expenses Commission within the Office of the Healthcare Advocate. The commission shall consist of the Healthcare Advocate, the Commissioners of Social Services and Public Health, the Insurance Commissioner and the Comptroller, or their designees, and ten additional members as follows:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(3) One appointed by the minority leader of the House of Representatives, upon the recommendation of the president and chief executive officer of the Connecticut Business and Industry Association and who shall represent employers that are self-insured;

(4) One appointed by the minority leader of the Senate, who shall represent the health insurance industry;

(5) Two appointed by the Attorney General, who shall be licensed health care providers who currently provide health care services to residents of the state; and

(6) Two appointed by the Governor, one of whom shall be a senior manager or human resources director of a labor union that offers a Taft-Hartley plan.

(b) The members appointed under subdivisions (1) to (6), inclusive, of subsection (a) of this section shall serve for terms of five years, except that the initial two members appointed by the Governor shall serve for terms of three and four years, respectively. Any vacancy shall be filled by the appointing authority. Members may be reappointed to serve consecutive terms. Members shall serve without compensation for their services but shall be reimbursed for their expenses.

(c) Any member appointed under subdivisions (1) to (6), inclusive, of subsection (a) of this section may be removed for cause, after a public hearing, by the official who appointed such member and may be suspended by such official pending the completion of such hearing.

(d) The members shall elect a chairperson and a secretary of the commission, neither of whom shall be a member of the General Assembly. The commission shall, by rule, determine the term of office of the chairperson and the secretary.

(e) Eight members of the commission shall constitute a quorum at any meeting. A vacancy in the membership of the commission shall not impair the right of a quorum to exercise all the powers and perform all the duties of the commission.

(f) The members of the commission shall be appointed not later than November 1, 2009, and the committee shall organize as soon as may be practicable after such appointment.

Sec. 4. (NEW) (*Effective July 1, 2009*) (a) The Catastrophic Medical Expenses Commission shall have the following powers and duties:

(1) To develop an application and establish procedures for applying for payment or reimbursement of medical and related expenses from the pool;

(2) To establish rules and procedures for determining the eligibility of applicants and the eligibility of requests for payment or reimbursement of medical and related expenses from the pool, including, but not limited to, (A) the documentation or information required from the applicant to substantiate the eligibility of the applicant or the request for payment or reimbursement, (B) methods to verify family income, (C) limits, if any, on the number of times an applicant may apply in a calendar year, (D) limits, if any, on the dollar amount that may be paid to an applicant in a calendar year, (E) whether an application submitted by a member of an applicant's family or payment made to such family member is aggregated in any such limits imposed on an applicant, and (F) methods to verify previous payments to an applicant, if necessary;

(3) To establish an approval process, including, but not limited to,

any criteria to be used to prioritize payments or reimbursements made from the pool, except that in the event the moneys in the account established under section 8 of this act are inadequate to cover all the requests made for payment or reimbursement, any applicant who is transitioning to medically needy status under the Medicaid program and who otherwise meets the criteria under sections 5 and 6 of this act shall be given preference for payment of reimbursement from the pool;

(4) To establish procedures for an applicant notification process, including, but not limited to, the time frames for the Office of the Healthcare Advocate to approve or deny an application or request for payment or reimbursement and for applicants to submit additional information if a denial was based on incomplete information;

(5) To establish a list of services, programs, treatments, products and expenses excluded under subsection (c) of section 6 of this act;

(6) To develop payment rates in accordance with subdivision (1) of subsection (a) of section 7 of this act;

(7) To establish criteria for and procedures to (A) preapprove payments pursuant to section 7 of this act, and (B) make payments or reimbursements, including, but not limited to, the method of payment and time frame for the Office of the Healthcare Advocate to process such payment;

(8) To establish procedures for repayment by an applicant to the pool where such applicant, after receiving payment from the pool, recovers the costs of medical and related expenses pursuant to a settlement or judgment in a legal action;

(9) To establish procedures by which moneys in the account established under section 8 of this act shall be expended, taking into consideration payments that have been preapproved pursuant to section 7 of this act and administrative costs to be paid as set forth in section 8 of this act;

(10) To develop an asset test to be used if pool funds appear to be inadequate to cover requests for payment or reimbursement;

(11) To make publicly available and update at least annually a list of (A) medical and related expenses that are eligible to be considered for payment or reimbursement from the pool, subject to the limitations and exclusions under sections 5 and 6 of this act, and (B) exclusions established pursuant to this subsection;

(12) To establish and maintain a record, electronic or otherwise, of each applicant. Such records shall be maintained in a secure location, shall be confidential and shall not be disclosed except as required by law and to members of the commission, provided such members agree, in writing, to keep such records confidential;

(13) To disseminate information to the public concerning the pool, including, but not limited to, the benefits available from the pool, procedures to apply and contact information for the Office of the Healthcare Advocate;

(14) To enter into contracts, within the moneys available in the pool, to carry out the provisions of sections 1 to 8, inclusive, of this act, including, but not limited to, entering into contracts with licensed physicians and clinicians to assist the commission in performing its duties and to designate persons who have the appropriate expertise to assist the commission in performing its duties;

(15) To accept grants of private or federal funds to the pool, and to accept gifts, donations or bequests including donations of services; and

(16) To take any other action necessary to carry out the provisions of sections 1 to 8, inclusive, of this act.

(b) The commission shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of subdivisions (1) to (10), inclusive, of subsection (a) of this section. The commission may adopt regulations, in accordance with chapter 54 of

the general statutes, to implement any other provision of sections 1 to 8, inclusive, of this act.

Sec. 5. (NEW) (*Effective July 1, 2009*) To be eligible to apply for payment or reimbursement from the pool, a person shall:

(1) Be covered by:

(A) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes;

(B) A self-insured comprehensive group medical or health care benefit plan. The Catastrophic Medical Expenses Commission shall determine what constitutes a comprehensive plan for the purposes of this subparagraph;

(C) The Municipal Employee Health Insurance Plan set forth in section 5-259 of the general statutes;

(D) The Charter Oak Health Plan set forth in section 17b-311 of the general statutes;

(E) A comprehensive individual or group health care plan set forth in section 38a-552 or 38a-554 of the general statutes;

(F) Medicare and a Medicare supplement insurance policy; or

(G) A high deductible plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal Revenue Code, provided such medical savings account or health savings account has been exhausted and subsequent medical and related expenses exceed the limits established in section 6 of this act.

(2) Not be eligible for benefits under Medicaid, HUSKY Plan or state-administered general assistance on the date the medical or related expenses for which reimbursement is requested from the pool were incurred;

(3) Be a resident of this state; and

(4) Be a citizen or resident alien of the United States.

Sec. 6. (NEW) (*Effective July 1, 2009*) (a) The amount of payment or reimbursement in a calendar year shall be limited to:

(1) For family income that is less than or equal to two hundred per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of eight per cent of such family income;

(2) For family income that is greater than two hundred per cent but less than or equal to three hundred per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of nine per cent of such family income;

(3) For family income that is greater than three hundred per cent but less than or equal to four hundred per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of ten per cent of such family income;

(4) For family income that is greater than four hundred per cent but less than or equal to five hundred per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of twelve and one-half per cent of such family income;

(5) For family income that is greater than five hundred per cent but less than or equal to one thousand per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of fifteen per cent of such family income; and

(6) (a) For family income that is greater than one thousand per cent but less than or equal to one thousand three hundred per cent of the federal poverty level, medical and related expenses paid by an applicant in a calendar year that is in excess of twenty-five per cent of such family income.

(b) An applicant with a family income that is greater than one thousand three hundred per cent of the federal poverty level shall not be eligible for payment or reimbursement from the pool.

(c) The following expenses shall be excluded from payment or reimbursement from the pool:

(1) Costs for services that would normally be provided by or available through (A) the birth-to-three program set forth in section 17a-248 of the general statutes, (B) the Department of Developmental Services, (C) the Department of Mental Health and Addiction Services, (D) the Department of Public Health, or (E) an individualized family service plan pursuant to section 17a-248e of the general statutes, an individualized education program pursuant to section 10-76d of the general statutes or any other individualized service plan;

(2) Costs for long-term care provided in a nursing home facility, rehabilitation facility or at home that exceeds or is expected to exceed six months;

(3) Premiums, copayments, deductibles, coinsurance and other out-of-pocket expenses paid by an applicant for a long-term care policy;

(4) Items that were denied because the insured or enrollee failed to comply with the terms of the insurer such as network or prior authorization requirements;

(5) Items that are not cost-effective or appropriate for the applicant's medical condition, as determined by the commission or persons designated by the commission pursuant to section 4 of this act. Such determination may be made separately from any decision made by an

insurer, health care center or utilization review company concerning such items. If said commission disagrees with such decision made by an insurer, health care center or utilization review company, said commission may be a party to an appeal filed by the applicant with such insurer, health care center or utilization review company;

(6) Infertility diagnosis and treatments;

(7) Massage services, natureopathy and other alternative medicine treatments or services;

(8) Dental braces, dentures, cosmetic dental procedures and routine dental services including, but not limited to, fillings, cleanings and other prophylaxis measures;

(9) Eyeglass frames costing over fifty dollars, adjusted annually to the increase in the consumer price index for urban consumers during the preceding twelve-month period according to the United States Bureau of Labor Statistics data;

(10) Pharmaceutical products, biological products or any substance that may be lawfully sold over the counter without a prescription under the federal Food, Drug and Cosmetics Act, 21 USC 301 et. seq., as amended from time to time;

(11) Vitamins or food supplements, unless prescribed for a diagnosed medical condition;

(12) Cosmetics;

(13) Services, treatments or products that are more expensive than equally effective alternatives, as determined by the commission or persons designated by the commission pursuant to section 4 of this act; and

(14) Other programs, services or expenses the commission may choose to exclude pursuant to regulations adopted in accordance with

chapter 54 of the general statutes.

(d) Payment or reimbursement from the pool for wheelchairs and hearing aids shall be limited to: (1) Once every biennium for persons under the age of eighteen years; and (2) once every ten years for persons over the age of eighteen years.

Sec. 7. (NEW) (*Effective July 1, 2009*) (a) If payment of a medical or related expense is preapproved by the Office of the Healthcare Advocate:

(1) Said office shall remit such payment to the insured's or enrollee's health care provider at the Medicare allowable rate for such medical or related expense. If there is no comparable Medicare allowable rate, said office, with the advice of the Catastrophic Medical Expenses Commission, shall develop a rate based on current Medicaid and insurer rates, or on rates negotiated by the Healthcare Advocate where no current Medicaid or insurer rate exists.

(2) Said office may preapprove a payment in accordance with the rules and procedures established by the commission, provided (A) the insured's or enrollee's health care or services provider has agreed, in writing, to accept such payment as payment in full on behalf of such insured or enrollee for such medical or related expense, (B) the insurer, health care center, self-insured employer, insured or enrollee, as applicable, provides any documentation or information required by said office to determine the eligibility of the applicant or the request for payment, and any previous payments made to such applicant from the pool, and (C) there are sufficient funds in the pool.

(3) Said office may preapprove payment of a related expense not typically considered medical if the commission or persons designated by the commission pursuant to section 4 of this act deem such related expense necessary to maintaining the independence of the applicant or the ability of such applicant to remain at home.

(b) If reimbursement of a medical or related expense is approved by the Office of the Healthcare Advocate:

(1) The applicant shall submit the bill to said office with proof of payment.

(2) Said office may pay all or part of such bill, based on (A) the rate said office would have paid pursuant to subdivision (1) of subsection (a) of this section, (B) the appropriateness and necessity of the particular medical or related expense, and (C) the availability of funds in the pool.

(c) Notwithstanding the provisions of chapter 319v of the general statutes, any payment or reimbursement to an applicant from the pool shall not be counted as income or assets for the purposes of determining eligibility for medical assistance.

Sec. 8. (NEW) (*Effective July 1, 2009*) (a) There is established an account to be known as the "catastrophic medical expenses account", which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Office of the Healthcare Advocate for the purposes of paying or reimbursing medical and related expenses, paying administrative costs and paying licensed physicians and clinicians contracted by the Catastrophic Medical Expenses Commission, in accordance with sections 1 to 8, inclusive, of this act.

(b) (1) Each insurer or health care center that delivers, issues for delivery, renews, amends or continues in this state individual or group health insurance policies or plans and third party administrator that provides services in this state under an administrative services only contract shall collect one dollar per life covered on January first of each year and shall remit such moneys to the Office of the Healthcare Advocate not later than thirty days after collection. All such moneys shall be deposited in the account set forth in subsection (a) of this

section.

(2) The Department of Revenue Services shall collect one dollar per life covered on January first of each year under the Charter Oak Health Plan set forth in section 17b-311 of the general statutes and shall remit such moneys to the Office of the Healthcare Advocate not later than thirty days after collection. All such moneys shall be deposited in the account set forth in subsection (a) of this section.

(c) The Office of the Healthcare Advocate shall pay all costs that do not exceed five per cent of the total amount transferred into the pool in a calendar year and are related to the management of the pool, including, but not limited to, costs for staff to manage the program and coordinate the work assigned by the commission, materials development, printing, postage and telephone expenses. Any such expenses that exceed five per cent of the total amount transferred into the pool in a calendar year shall require approval for payment by the commission.

(d) The Commissioner of Social Services shall seek any federal matching funds available for the pool.

(e) When the moneys in the account have been exhausted, no payments or reimbursements shall be made until moneys have been deposited in the succeeding calendar year pursuant to subsection (b) of this section.

Sec. 9. Section 38a-1041 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) There is established an Office of the Healthcare Advocate which shall be within the Insurance Department for administrative purposes only.

(b) The Office of the Healthcare Advocate may:

(1) Assist health insurance consumers with managed care plan

selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

(2) Assist health insurance consumers to understand their rights and responsibilities under managed care plans;

(3) Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process established under section 38a-478n;

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

(6) Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

(7) Ensure that health insurance consumers have timely access to the services provided by the office;

(8) Review the health insurance records of a consumer who has provided written consent for such review;

(9) Create and make available to employers a notice, suitable for posting in the workplace, concerning the services that the Healthcare Advocate provides;

(10) Establish a toll-free number, or any other free calling option, to allow customer access to the services provided by the Healthcare Advocate;

(11) Pursue administrative remedies on behalf of and with the consent of any health insurance consumers;

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive.

(c) The Office of the Healthcare Advocate shall make a referral to the Insurance Commissioner if the Healthcare Advocate finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

(d) The Healthcare Advocate and the Insurance Commissioner shall jointly compile a list of complaints received against managed care organizations and preferred provider networks and the commissioner shall maintain the list, except the names of complainants shall not be disclosed if such disclosure would violate the provisions of section 4-61dd or 38a-1045.

(e) On or before October 1, 2005, the Managed Care Ombudsman, in consultation with the Community Mental Health Strategy Board, established under section 17a-485b, shall establish a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families. On or before January 1, 2006, and annually thereafter, the Healthcare Advocate shall report, in accordance with the provisions of section 11-4a, on the implementation of this subsection to the joint standing committees of the General Assembly having cognizance of matters relating to public health and

insurance.

(f) On or before October 1, 2008, the Office of the Healthcare Advocate shall, within available appropriations, establish and maintain a healthcare consumer information web site on the Internet for use by the public in obtaining healthcare information, including but not limited to: (1) The availability of wellness programs in various regions of Connecticut, such as disease prevention and health promotion programs; (2) quality and experience data from hospitals licensed in this state; and (3) a link to the consumer report card developed and distributed by the Insurance Commissioner pursuant to section 38a-478*l*.

(g) The Office of the Healthcare Advocate shall administer the catastrophic medical expenses pool established under section 2 of this act, and shall make payments and reimbursements in accordance with sections 1 to 8, inclusive, of this act. Said office may adopt regulations, in accordance with chapter 54, to implement the provisions of sections 1 to 8, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	New section
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	New section
Sec. 6	*July 1, 2009*	New section
Sec. 7	*July 1, 2009*	New section
Sec. 8	*July 1, 2009*	New section
Sec. 9	*July 1, 2009*	38a-1041

Statement of Purpose:

To create a catastrophic medical expenses pool to help defray medical and related expenses that exceed a threshold percentage of family income for persons who are insured but have catastrophic medical expenses.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: REP. SCHOFIELD, 16th Dist.

H.B. 6152